Ensuring Access to Pediatric Dental Benefits in the Affordable Care Act (ACA)

The Affordable Care Act (ACA) represents a significant opportunity to expand dental coverage to millions of children nationwide. By including oral health services as part of the pediatric essential health benefits (EHB), Congress recognized that oral health is a critical piece of overall health. That message is timely; today, tooth decay remains the most common chronic condition among American children. With 26 percent of preschool age children, 44 percent of kindergarteners, and more than half of adolescents experiencing preventable tooth decay, the impact of this disease cannot be ignored.[1,2]

Despite pediatric dental benefits being part of the EHB, the separate treatment of dental and medical benefits in the law and subsequent federal regulations poses a number of challenges to ensuring that all children have access to affordable, high quality dental coverage. Concerns continue to surface regarding the integration of pediatric dental benefits into the coverage that must be offered on the new health insurance Exchanges and in the existing small group and individual insurance markets in each state.

The following brief outlines the current issues facing the pediatric dental benefit as a part of the essential health benefits package and its relationship to the Exchange. The five issues are 1) affordability; 2) access to dental care; 3) consumer protections that apply to pediatric dental care; 4) robustness of benefits; and 5) how the benefit will be sold inside the Exchange versus state insurance markets. The brief then presents advocates with some action steps and recommendations as we monitor implementation of the ACA.

Issue #1: Affordability

Tax credits: The ACA subsidizes the purchase of health insurance in the form of premium tax credits for families earning up to 400 percent of the federal poverty level (FPL) or about $78,000 for a family of three. Families who purchase two health plans – medical-only coverage from one insurer and pediatric dental coverage from another – will have two separate premium payments. HHS regulations clarify that under this scenario, the premium tax credit is *first* paid to the medical insurer (called a qualified health plan or QHP) and any remaining credit paid to the dental insurer.[3]

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[1] Centers for Disease Control and Prevention and the American Dental Association. Fluoridation: nature's way to prevent tooth decay. Available at http://www.cdc.gov/Fluoridation/pdf/natures_way.pdf

[2] Dye BA, Tan S, Smith V, Lewis BG, Barker LK, Thornton-Evans G, et al. (2007), Trends in oral health status, United States, 1988-1994 and 1999-2004. National Center for Health Statistics. Vital Health Stat 11(248)

[3] 45 CFR 155.340

However, IRS is currently interpreting the rule on the Health Insurance Premium Tax Credit[4] such that a family's premium tax credit amount would not be increased as a result of purchasing stand-alone pediatric dental coverage. Under this interpretation, it is unlikely that a family purchasing silver-level coverage through an Exchange would have any residual tax credit to cover the cost of stand-alone dental benefits. Because these subsidies are tied to the second lowest cost silver plan sold in each Exchange, a family would have to purchase significantly cheaper medical coverage in order to have any tax credit left over to support the purchase of stand-alone dental coverage.

Cost sharing: The ACA establishes limits on how much a family can pay out-of-pocket for EHB services. However, the HHS rule on Standards Related to Essential Health Benefits allows for a separate "reasonable" cost-sharing limit for stand-alone dental plans in addition to the out-of-pocket limits established by the statute, effectively increasing a family's maximum out-of-pocket expenses by a considerable margin.[5] While the rule does not specify what a reasonable out-of-pocket limit should be, plan designs submitted to some State-based Exchanges include separate out-of-pocket maximums up to $1,000 per child. For Federally-facilitated Exchanges (FFE) and Partnership Exchanges, the HHS final letter to issuers allows for a separate out-of-pocket maximum for stand-alone dental that is at or below $700 per child and $1,400 for families with two or more children.[6]

Role of advocates:
Encourage Exchanges to offer pediatric dental benefits as a part of overall health insurance coverage. Coordinated benefits should protect families from incurring additional out-of-pocket maximums and premium payments. When families can purchase health insurance that includes pediatric dental coverage, their premium subsidy will be tied to the entire product and will protect families from dual premiums and of out of pocket maximums that layer cost on families with limited financial relief.

Advocates should identify key state stakeholders and determine how decisions about the dental benefit are being made. In the case of an FFE, your target may be Departments of Insurance (DOI) and Administrations at the state level, and CCIIO at the federal level. As with most Exchange or EHB related advocacy, the state DOI or Exchange Board will most likely drive decisions. Remember that even if your state has an FFE or a Partnership Exchange, HHS is relying on state DOIs to play an important role in QHP review and certification.

On the federal level, national consumer advocates are working to influence a regulatory change to ensure that families will receive a tax credit based on all of the EHBs, regardless of how they purchase pediatric dental coverage. Stay tuned for any state level consumer advocacy group actions to support this change.

Advocates should continue to educate and engage stakeholders about the importance of shielding families from costs that create additional barriers to children's access to dental care.

[4] 26 CFR 1.36B–3
[5] 45 CFR 156.150
[6] Center for Consumer Information and Insurance Oversight. "Letter to Issuers on Federally-facilitated and State Partnership Exchanges." 5 April 2013.

Issue#2: Access to Dental Care

One issue regarding the pediatric dental benefits is whether or not families will be required to purchase dental coverage. While the EHB requires a dental benefit to be offered, the law and subsequent regulations do not require it to be purchased when offered separately on the Exchanges.[7,8] When the benefit is offered separately from a health insurance plan through a stand-alone plan, there may be an incentive to opt out of purchasing dental coverage if a family is concerned about the added cost.

Role of advocates:

Support efforts to integrate dental care into health plans so families can purchase health insurance coverage that treats dental at parity with other health benefits. The caveat is an important one, however. **DO NOT** support measures that force families to purchase dental care without strong affordability protections. While requiring families to purchase a dental benefit may be in the best interest of a child or children, it may risk a families' financial stability absent inclusion of stand-alone dental plans in premium subsidy calculation and more robust safeguards for out-of-pocket expenses.[9]

Advocates should talk with stakeholders about the potential consequences of mandating purchase of dental care. While this is an admirable goal, in order for it to work in the interest of children and families, the purchase of dental coverage should be supported by premium tax credits, cost-sharing reductions, and an out-of-pocket maximum that does not exceed the limit outlined in statute. Additionally, families should have the full range of consumer protections available to them when purchasing stand-alone dental coverage.

Issue#3: Consumer Protections

While the ACA established a number of market reforms and consumer protections in private insurance marketplaces, many of those protections do not apply to stand-alone dental plans. HHS regulations do require stand-alone dental plans to offer child-only plans and apply the law's requirement for cost-sharing limits to stand-alone dental plans as well as the prohibition against annual and lifetime dollar limits on coverage.[10] Additionally, stand-alone dental plans are required to comply with relevant QHP certification standards such as network adequacy. Stand-alone dental plans are exempt from a number of other important consumer protections including:

- medical loss ratio requirements
- restrictions on rating standards and guaranteed rates
- reduction of cost-sharing for families up to 250 percent FPL
- prohibition against denial of coverage for pre-existing conditions
- prohibition against rescission
- right to an external appeals process

[7] Patient Protection and Affordable Care Act section 1302(b)(4)(F)
[8] 45 CFR 156.150
[9] Section 1402(c)(5) of the Affordable Care Act exempts stand-alone dental plans from the requirement imposed on QHPs to reduce cost-sharing for low-income families by effectively increasing the actuarial value of their benefit plans.
[10] 45 CFR 156

Role of advocates:
Educate stakeholders about the potential risk to consumers in not having all the consumer protections that the ACA promises, especially in states where Medicaid and CHIP eligibility does not extend at least to 250 percent FPL as low-income families in those states will not receive cost-sharing reductions for stand-alone dental benefits. **In order to receive the full range of consumer protections for pediatric dental benefits a family would need to purchase a QHP that embeds such benefits.**

Advocates should continue to educate the public and legislators about the missing protections for stand-alone pediatric dental coverage and building the case for expanded consumer protections in future state actions, including legislation and Exchange governance decisions. They should also monitor how the absence of these protections will affect kids and families.

Issue #4: Robustness of benefits

Every state but Utah has selected the dental benefits outlined in either the state's CHIP program or the Federal Employees Dental and Vision Insurance Program (FEDVIP) as the benchmark for the pediatric dental portion of their essential health benefits. While the range of services covered by those benchmarks is generally comprehensive, insurers may still have a great deal of flexibility in designing the dental benefit products with regard to service limits, cost-sharing structure, deductibles, and rates. Depending on how specific each state's standard plan designs are, consumers may encounter dental insurance products that charge deductibles and co-insurance even for preventive services which have traditionally been provided at no additional cost, especially for children. The disease that causes tooth decay takes hold early in life; therefore, it is important that children be able to access routine and preventive care without additional financial barriers.

Role of advocates:
Support plan designs that are comprehensive and assure access to preventive services at no cost to families. Advocates should engage Exchange staff and policymakers to ensure that standard plan designs avoid co-payments for routine office visits or co-insurance for children's preventive dental services and that any deductibles do not apply to these services. If this is unavoidable, advocates should work to ensure families understand the structure of benefits available to them so that they can choose the dental benefit that is most beneficial to their child's oral health. Navigators can play an important role in informing families of their dental benefit options.

Issue #5: Exchanges versus the outside market

The ACA requires that Exchanges allow stand-alone dental plans to participate in order to offer pediatric dental coverage as an EHB. However, it also exempts QHPs from the requirement to offer pediatric dental coverage if a stand-alone is participating in the Exchange. This policy, coupled with the fact that stand-alone dental coverage is not a requirement under the law's individual responsibility requirements, enables families to bypass purchase of dental coverage for kids.

The policy is different outside of the Exchange. Outside of the Exchange, dental benefits will either need to be embedded in health plans in order to meet requirements for EHB or these plans

will need to have "reasonable assurance" that enrollees with children have purchased stand-alone pediatric dental coverage that is equivalent to that offered in the Exchange. Therefore, families will purchase pediatric dental coverage as part of their general health insurance coverage in the small group and individual markets outside of the Exchange.

Role of advocates:
Support the embedding of the benefit in the outside market as a model for plans inside the Exchange.

Advocates should monitor the interplay between plans in the Exchange that include dental benefits and do not. It will be important to note whether the availability of different plan options impact child enrollment and access to care. Additionally advocates should examine whether the plans offered in the individual and small group markets might serve as a model for a more coordinated approach to pediatric health and dental benefits. This information may prove helpful when the EHB is reviewed in 2015.

Conclusion

The federal regulatory approach with regard to pediatric dental benefits in the exchanges poses ongoing challenges to providing children with robust and accessible dental coverage. Advocates can continue to play an important role in shaping how their state addresses dental benefits under the ACA, monitoring how the state's approach affects children and families, and making ongoing recommendations to influence how children get dental benefits in the future.

Authored by
Eva Marie Stahl, Project Director
New England Alliance for Children's Health

Colin Reusch, Senior Policy Analyst
Children's Dental Health Project